Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

DENTURE/PARTIAL APPLIANCE REQUEST FOR SKILLED NURSING FACILITY CLIENT

DATE OF REQUEST	CLIENT PIC NUMBER	FACILITY NAME	CLIENT NAME

ITEM/SERVICE REQUESTED

THE FOLLOWING INFORMATION IS REQUIRED FOR ALL SKILLED NURSING FACILITY CLIENTS

***This form is to be completed and signed by the client's primary physician or registered nurse only.**

A statement from the dentist or denturist stating that the prior authorization request is medically necessary should be attached to this form.

Yes	No	
☐	☐	Is this the client's first set of denture/partial?
		If not how old are previous appliances and why do they need to be replaced?
☐	☐	Is patient alert and oriented?
☐	☐	Would client be compliant with the daily use of a dental appliance?
☐	☐	Does your facility have staff available to ensure and/or assist with proper cleaning techniques and daily insertion and removal?
☐	☐	Would the use of the requested appliance enhance this resident's quality of life through improved nutritional intake?
☐	☐	Does the resident eat solid food?
☐	☐	Can the client consent to treatment? If not, attach a signed release form by the designated power of attorney to this form.

List all medical diagnosis

MD OR RN SIGNATURE	DATE

Return this form to the servicing provider